

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155266		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 08/16/2012	
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF FORT WAYNE				STREET ADDRESS, CITY, STATE, ZIP CODE 1649 SPY RUN AVENUE FORT WAYNE, IN 46805			
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F0000	<p>This visit was for the Investigation of Complaint IN00112034.</p> <p>Complaint IN00112034-Substantiated. Federal/state deficiency related to the allegation is cited at F323.</p> <p>Survey date: August 15, 16, 2012</p> <p>Facility number: 000167 Provider number: 155266 AIM number: 100273740</p> <p>Survey team: Ann Armey, RN</p> <p>Census bed type: SNF/NF: 71 Total: 71</p> <p>Census payor type: Medicare: 6 Medicaid: 56 Other: 9 Total: 71</p> <p>Sample: 4</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2.</p>			F0000	<p>This plan of correction is the facility's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed because the provisions of federal and state law require it.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Quality review completed on August 21, 2012 by Bev Faulkner, RN						

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F0323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>A. Based on observation, interview and record review, the facility failed to ensure a resident was safely positioned, failed to assure a call light was within reach to summon for assistance and failed to provide adequate supervision to prevent accidents for 1 of 1 residents reviewed for fractures in the sample of 4. Resident # B</p> <p>B. Based on interview and record review, the facility also failed to provide supervision to prevent a resident from leaving the facility unattended for 1 of 3 residents reviewed at risk for elopement in the sample of 4. (Resident # C)</p> <p>Findings include:</p> <p>A.1. On 8/15/12 at 10:20 a.m., during the orientation tour, LPN #10 indicated Resident #B had sustained two fractures; a fractured left femur and a fractured right ankle. The resident was observed to be lying in bed on an alternating air mattress in her room.</p>			F0323	<p>It is the policy of this facility to ensure each resident receives adequate supervision and assistance to prevent accidents.</p> <p>Corrective action for residents affected: A. Resident B: Therapy and CNA were re-educated on turning and repositioning resident with 2 staff assistance. Plan of care and care guide were updated. Resident B was assessed by the Nurse Practitioner and evaluated by Orthopedic surgeon. She is being assisted by 2 staff at all times during bed mobility and transfers, and her call light is within reach at all times. Call light is secured to the trapeze, as needed, to prevent sliding. Side rails of ¾ size were added to the bed. B. Resident C is no longer residing in the facility.</p> <p>Other residents having the potential to be affected and corrective action: A. All residents identified as requiring staff assistance in bed mobility and transfers have the potential to be affected. A 100% audit of care guides, MDS and care plans will be completed by 9/4/12 by the Director of Nursing (DON) and/or designee, in order to ensure</p>		09/15/2012

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	<p>On 8/15/12 at 10:25 a.m., Resident #B was queried about how she sustained her fractures.</p> <p>Resident #B indicated she was being turned for a treatment by the therapist and when the therapy lady moved her leg, she heard a pop. The resident indicated about a week later she found out she had a hip fracture.</p> <p>Resident #B indicated on another occasion, she was turned on her side by an aide so her treatment could be done. The aide left, but she couldn't reach her call light because she was on her side and the call light was on the trapeze, as usual, but it had been pushed back on the bar. The resident indicated she felt her air mattress moving or "rotating", and she tipped out of bed. Resident #B indicated she held onto the rail, her feet were against the wall and her upper body was still on the bed. The resident indicated she hurt her right ankle when she slipped out of bed.</p> <p>On 8/15/12 at 10:45 a.m., the clinical record of Resident #B was reviewed and indicated the resident was admitted to the facility on 8/23/96, with diagnoses which included but were not limited to, multiple sclerosis, obesity, cerebral vascular disease, spinal stenosis, seizure disorder, chronic right gluteal pressure ulcer and diabetes mellitus.</p>				<p>assistance required for bed mobility and transfers is correctly identified for nursing and therapy staff providing care. B. All residents identified as elopement risk have the potential to be affected. All nurse stations have binders identifying residents at risk for elopement. Measures to ensure practice does not recur:</p> <p>A. On 9/4/12 and 9/6/12, nursing and therapy staff will be re-educated by the DON and/or designee regarding prevention of accidents as related to bed mobility and transfers, proper positioning and call light placement. Daily, Monday through Friday, the DON and/or designee will make random inspections of care provided to 6 residents during transfers and/or bed mobility, in order to check for adherence to care guides/care plan interventions, proper positioning, and proper placement of call lights. B. Brightly colored signs were placed at all facility exit doors, alerting visitors to the use of door codes and alarms for resident safety and instructing them to not let anyone out that they do not personally know. Staff will be re-educated on elopement policy on 9/4 /12 and 9/6/12 by the DON and/or designee. Families will be notified via monthly mailing regarding the use of door codes and alarms and will be instructed to not assist anyone out of the building that they do not personally know.</p>		

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	<p>The MDS (Minimum Data Set) Assessments, dated 6/2/12 and 8/5/12, indicated Resident #B had no cognitive impairments and required extensive assistance of two staff persons for bed mobility and transfers.</p> <p>Fall Risk Assessments done on 6/14/12, 7/10/12, and 8/9/12, indicated the resident was at high risk for falls.</p> <p>The Fall Care Plan, initiated 1/17/08, and revised 5/18/12, indicated the resident was at risk for fall related to her multiple sclerosis, decreased mobility, seizure disorder and history of non-compliance. The care plan had the following care interventions, which included but were not limited to:</p> <p>Complete fall assessments quarterly, Transfer with Hoyer lift with at least 2 staff to assist for safety to her motorized wheelchair, Use reacher, Keep belongings organized, Assess pain and provide medication, Keep call light within reach and answer promptly, Use side rail as an enabler, Observe for adverse side effects from medication, and Place items within reach. The fall care plan was revised on 8/1/12</p>		<p>Maintenance staff will change door codes monthly, in order to provide more security for residents at risk for elopement. Maintenance staff or designee will check all exit doors for placement of signage related to the door codes and alarms. Corrective action to be monitored by: A. All audits regarding adherence to required assistance during care and call light placement will be completed by the DON and/or designee daily, Monday through Friday, for 30 days, then monthly for 6 months. B. Maintenance staff or designee will check signage at exit doors weekly for 4 weeks, then monthly for 6 months. C. The results of all audits will be taken to the monthly performance improvement meeting for review, with the plan updated as indicated.</p>				

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	<p>and 8/16/12, and included the following interventions:</p> <p>The bed should be in the lowest position, Provide ongoing education on the benefits of low bed, bariatric bed and air mattress setting, Provide therapy referral, Provide 3/4 rails, and Provide 2 staff for all care procedures and for all transfers.</p> <p>The Care Directive, dated 7/30/12 and 8/2/12, indicated the resident was a "Total" for bed mobility. The safety devices to be used were trapeze and half rails on the right and left.</p> <p>The Care Directives, revised 8/10/12, indicated the resident's safety devices, should include; low bed, mat beside bed, trapeze, falling star program, air mattress setting at #10 per resident request, and two staff to assist with care at all times.</p> <p>The following information is related to the fractured left femur, as follows: On 7/2/12, therapy notes indicated; "...PT (Physical Therapist) attempted to help pt (patient) roll to LT (Left) side for wound care. Pt's left knee "popped," and pt c/o (complained of) Lt knee pain. NP (Nurse Practitioner) assessed pt's knee and stated it was a muscle spasm. PT (Physical Therapist) massaged pt's Lt</p>						

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	<p>(Left) knee/quad to relieve muscle spasm and re-attempted bed mobility. Pt attempted but was unable secondary to knee pain. PT (Physical Therapist) left and came back 1 hour later, but pt's knee was still hurting during bed mobility. PT (Physical Therapist) was unable to roll pt to perform wound care.</p> <p>On 7/2/12, Nurse Practitioner's progress notes indicated the resident was seen at the request of staff. The note indicated the resident was turned for wound therapy and complained of left leg pain. The note indicated the resident's left extremity had no deformity, swelling, length discrepancy or external rotation.</p> <p>On 7/3/12 at 6:46 p.m. and 7/4/12 at 8:45 p.m., nursing notes indicated the resident had no complaints of discomfort or pain.</p> <p>On 7/9/12 at 9:26 a.m., nursing notes indicated the resident complained of pain and x-rays of the left hip, knee, and femur were ordered.</p> <p>An x-ray report, dated 7/9/12, indicated the resident had an acute fracture of the proximal left femur and of the left femoral diaphysis (shaft or middle part of the upper leg bone).</p> <p>On 7/9/12 at 7:11 p.m., the resident was transported to the hospital.</p>						

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	<p>The Hospital X-ray report, dated 7/9/12, indicated the resident had a mildly displaced, mildly comminuted intertrochanteric fracture of the left proximal femur and diffuse osteopenia.</p> <p>The incident report sent to the ISDH (Indiana State Department of Health), dated 7/9/12, indicated in part "Resident who is totally dependent for transfers complained of left leg pain, origin uncertain."</p> <p>On 7/10/12 at 6:14 p.m., nursing notes indicated the resident was returned to the facility</p> <p>On 8/15/12 at 1:15 p.m., Physical Therapist #12, who turned Resident # B on 7/2/12, was interviewed. She indicated, on 7/2/12, she was attempting to turn Resident #B on her left side. The Therapist indicated she pulled Resident #B toward her, the resident asked her to move her left leg and when she did she heard a pop.</p> <p>Per interview, on 8/16/12 at 2:30 p.m., Physical Therapist #12 indicated she felt the resident could be safely turned with one staff person.</p> <p>The following information is related to the incident on 8/9/12, as follows: On 8/9/12 at 3:08 p.m., nursing notes</p>						

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	<p>indicated "at 12:30p [sic] resident was found partialy [sic] on the floor top half was in bed and bottom of body on floor cna had positioned resident for treatment to buttocks cna left to get nurse for tx (treatment)..." The note indicated x-rays had been ordered.</p> <p>An incident statement, dated 8/9/12, from CNA #11, who had been caring for Resident #B indicated "I proceeded to clean (Resident #B's Name) I rolled her over onto her side for her to receive her treatment. I walked out of the room after 11:30 because I was paged to the dining room I was there until 12:00 went straight to (Resident #B's name) room to finish her & (and) get her up. When I walked in she was on the floor her bottom half I stepped in the hallway and asked (Staff Name) for help she came in and we waited for other staff. I asked (Resident #B's Name) what happened and she said the bed rolled her..." The statement further said the times were estimates but she got to the dining room at 11:30 a.m.</p> <p>The X-ray report, dated 8/9/12, indicated the resident had a right distal tibial (lower leg bone) fracture.</p> <p>Physician orders, dated 8/9/12, referred Resident #B to the orthopedic clinic.</p>						

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	<p>The ISDH incident report, dated 8/9/12, indicated "Resident...who is totally dependent for transfers was observed on the floor. The report indicated the resident had a distal tibial fracture of the right leg.</p> <p>On 8/10/12 at 9:22 a.m., nursing notes indicated Resident #B was to be seen by the orthopedic clinic on 8/10/12 at 1:00 p.m.</p> <p>Physician orders, dated 8/10/12, indicated the resident was to be on bed rest until a patellar stabilizer was available.</p> <p>On 8/10/12 at 6:15 p.m., nursing notes indicated the resident had received education regarding the negative outcomes of not allowing a bariatric bed with new mattress, bed rest, and low bed.</p> <p>On 8/16/12 at 8:49 a.m., a report from the orthopedic clinic, dated 8/10/12, was faxed to the facility. The report indicated, in part, that the resident was seen for evaluation of her right ankle and knee. The report further indicated that X-rays showed the resident had an "old fracture of the distal tibia, but good healing with this. No new findings are noted. Hardware is in place."</p> <p>Per interview, on 8/15/12 at 12:15 p.m., CNA #11, indicated she cleaned Resident</p>						

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	<p>#B up and was paged to the dining room. She indicated she couldn't leave the dining room and when she got back to Resident #B's room she had slipped partially out of bed. CNA #11 indicated she left Resident #B's call light attached to the trapeze triangle above the bed which, was the usual routine. The aide indicated Resident #B was turned on her left side and was in the middle of the bed. The CNA indicated she normally didn't leave the resident, but she was paged to the dining room.</p> <p>Per interview on 8/16/12 at 9:30 a.m., the acting DON (Director of Nursing) indicated Resident # B needed a bariatric bed but the resident refused and as a result, two staff were now providing care for the resident at all times.</p> <p>B.1. The closed clinical record of Resident #C was reviewed on 8/15/12 at 3:00 p.m., and indicated the resident was admitted to the facility on 3/17/12 with a diagnosis which included but was not limited to, bipolar disorder, and bladder cancer.</p> <p>The elopement assessment, dated 3/17/12, indicated she had risk factors related to elopement.</p>						

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	<p>The Minimum data set assessment, dated 6/10/12, indicated the resident had moderate cognitive impairment, and had exhibited no physical, verbal, wandering or other behaviors.</p> <p>On 7/7/12 at 10:45 a.m., nursing notes indicated Resident #C hit her roommate in the face and was taken to the nurses' station for one on one observation until she could be transferred to the behavioral unit.</p> <p>On 7/9/12 at 3:38 p.m. and 4:53 p.m., nursing notes indicated the resident was readmitted to the facility and had a room without a roommate.</p> <p>A hand written note indicated she was receiving 15 minute checks after her return from the hospital.</p> <p>On 7/9/12 at 9:14 p.m., nursing notes indicated the resident was out in parking lot with her clothes in a bag and became physically aggressive when staff attempted to return her to the facility. The note indicated an order was received to return the the resident to the behavioral center.</p> <p>On 7/10/12 at 7:10 a.m., the resident was returned to the behavioral unit.</p>						

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	<p>An investigative statement from LPN #13, who was on duty at the time of the incident, dated 7/9/12, at 10:30 p.m., indicated "I answered the phone around 7:40 p.m. to a lady telling me 'there is a lady in the parking lot c (with) a walker and a bag just sitting there I think she belongs there.' I checked (Resident #C's name)'s room...and told a CNA CNA (Sic) to go check the front lot for the res (resident) et told the other nurse to check the back door et I went c CNA to check the front parking lot where I obtained (sic) res (resident) sitting on her walker c (with) a bag in front of her...."</p> <p>An investigative statement from LPN #14 indicated she had seen the resident walking in the hall at 7:40 p.m.</p> <p>The incident was reported to the ISDH (Indiana State Department of Health).</p> <p>LPN #13 was interviewed on 8/16/12 at 12:00 noon, and indicated an unknown female called the facility and said there was a lady in the front parking lot. The nurse indicated he was not sure how Resident #C got out since she didn't know the code and he thought she must have been let out by a visitor.</p> <p>On 8/16/12 at 1:45 p.m., the front, back and therapy exit doors were observed.</p>						

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>There was a sign on the back door indicating "This facility uses door codes and alarms for resident safety. Please do not let anyone out that you do not know." There was no sign on the front or therapy doors.</p> <p>On 8/16/12 at 3:00 p.m., the DON (Director of Nursing) indicated Resident #C was discharged from the facility after the incident. She indicated there was a sign on the back door alerting visitors not to let residents out but no signs were placed on the front or therapy doors until 8/16/12.</p> <p>This Federal tag relates to Complaint IN00112034.</p> <p>3.1-45(a)(2)</p>						